Patient Information

Identifying Information:

Client Name:_____ Date of Birth: _____

Age:_____ Gender: _____

Race: _____ Residence (City): _____

Medication Allergies:_____ Marital Status: M D S W

Occupation:_____ Currently Employed: Y N

PCP: _____ Pharmacy #: _____

Presenting Problems:

Brief Description of Current Problems:

_____

_____

_____

Psychiatric medications (use an additional page if necessary)

Current:

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Past: _____

Other Medications: (to include Vitamins, Herbals, etc.)

_____

Past Treatment:

Current/Past psychiatric diagnosis: _____

Previous Psychiatric Treatment:

In-Patient:	When: _____	When: _____
	Where: _____	Where: _____
	Why: _____	Why: _____
Out-Patient:	When: _____	When: _____
	Where: _____	Where: _____

Suicide Attempts: Y N If yes, _____

Habits:

Tobacco: _____ppd: _____ years: _____ Alcohol current: _____Past: _____

Caffeine _____cups coffee/day _____colas/day _____glasses of tea/day

Substance Abuse:

Please circle: None Past Present

Substance Used: _____ Age of Onset: _____

Amount/Frequency of Use: _____ Length of Use: _____

Consequences of Use: _____

Medical History:

Developmental Delays: Y N If yes: _____

Current/Chronic Illness: Y N If yes:

_____

_____

Surgeries: Y N If yes, _____

Head Injuries/Seizures: Y N If yes: _____

Difficulties during Delivery/Pregnancy: Y N If yes: _____

Current Nutritional Status: Weight: _____ Height: _____

Female Only: Age of onset of period:_____ Last period: _____ Birth control: _____

Age of Menopause: _____ Hormone replacement: _____

Family History:

Medical: Mother side: _____

Father side: _____

Sibling/Children: _____

Social History:

Current residence (City/State): _____

Name/Age of children: _____

#/Duration of Marriages: _____

Who lives in the home:

_____

_____

Childhood History:

Where were you born and raised: _____

Level of Education: _____

Number of siblings: Brothers: _____ Sisters: _____

Relationships:

Abuse: Physical/Sexual/Emotional Y N If yes,

_____

_____

Financial Issues: Y N If yes: _____

Legal Issues: Y N If yes: _____

_____ _____

Patient Signature Date

I have reviewed with patient and revised as needed the above patient information: Y N

_____ _____

Physician Signature Date

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
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ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: _____ **Date Completed**: _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					